Fee **$115.50 U.S.** ($105.00 application fee and $10.50 eLicensing surcharge per MN Statute Sec. 16E.22). No personal checks. All fees are nonrefundable.

Minnesota BOARD OF Nursing

2829 University Avenue SE #200
Minneapolis, MN 55414-3253
(612) 317-3000 – Voice (612) 617-2190 – Fax
Toll Free (888) 234-2690 (MN, IA, ND, SD, WI)
(800) 627-3529 – TTY
Email: nursing.board@state.mn.us
Website: www.nursingboard.state.mn.us

ADVANCED PRACTICE REGISTERED NURSE LICENSURE APPLICATION

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine your eligibility and/or qualifications for the license for which you are applying; enable us to contact you when necessary; identify you and comply with certain federal and state reporting requirements. Minnesota Statute Sec. 270C.72 requires applicants to provide their Social Security number and Minnesota business identification number on all license applications.

Until you are issued a license, all data submitted on the application, except your name and address, are considered private data and will not be released to anyone other than Board of Nursing staff and its agents. When you become licensed, all data submitted on the application, except social security number and responses to grounds for denial questions, become public record. Some or all of the data may be given to the Commissioner of Revenue, the Legislative Auditor, in response to a court order, or others in accordance with statutes, rules and professional standards.

You are legally required to submit true and complete information. Furnishing the requested information means the information may be provided to parties listed above. Refusal to supply information may result in denial of a license. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

•Type or print clearly •Use black ink •Provide all information •Incomplete applications will be returned •Do not use initials or abbreviations

APPLICANT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
MAIDEN NAME	OTHER LAST NAME(S)	PHONE NUMBER ☐ Home ☐ Business ( )
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE / COUNTRY
EMAIL ADDRESS		
MINNESOTA LICENSE NUMBER ☐ RN _____	BIRTH DATE (mm/dd/yyyy)	GENDER ☐ Male ☐ Female
UNITED STATES SOCIAL SECURITY NUMBER Required by Minn. Stat. Sec. 270C.72 ___-___-____	☐ I do not have a US Social Security number at this time but will notify the Board if/when I obtain a US Social Security number	MINNESOTA BUSINESS IDENTIFICATION NUMBER Required by Minn. Stat. Sec. 270C.72
APRN PROGRAM NAME		COMPLETION DATE (mm/dd/yyyy)

BUSINESS ADDRESS: Minn. Stat. Sec. 214.073 requires licensees to provide their primary business address at the time of initial application and all renewals. Your license will not be issued unless you provide it or check the box below certifying that you are not currently in the workforce related to your practice.

FACILITY NAME		
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE

☐ I certify that I am not currently in the workforce related to my practice and I don't have a business address related to my practice.

APRN ROLE (A separate application is required for each role)

☐ NURSE PRACTITIONER ☐ NURSE MIDWIFE
☐ NURSE ANESTHETIST ☐ CLINICAL NURSE SPECIALIST

POPULATION FOCUS (Check all statements that apply)

☐ ADULT GERONTOLOGY	☐ PEDIATRIC	☐ PSYCHIATRIC/MENTAL HEALTH
☐ NEONATAL	☐ ACUTE CARE (if appropriate)	☐ PRIMARY CARE (if appropriate)
☐ WOMEN'S HEALTH	☐ FAMILY	

-OVER-

CURRENT CERTIFICATION

Applicant must request documentation of current certification in good standing be sent directly from the certifying body to the Board.

CERTIFYING ORGANIZATION	CERTIFICATION TYPE	EFFECTIVE DATE	EXPIRATION DATE
CERTIFYING ORGANIZATION	CERTIFICATION TYPE	EFFECTIVE DATE	EXPIRATION DATE

PRESCRIBING

PRESCRIBING PHARMACOLOGICAL INTERVENTIONS	☐ YES ☐ NO
PRESCRIBING NON-PHARMACOLOGICAL INTERVENTIONS	☐ YES ☐ NO

DEA NUMBER	STATE ISSUED
DEA NUMBER	STATE ISSUED

GROUNDS FOR REVIEW OF APPLICATION
Provide a written explanation for every Yes response.

1. Have you ever violated a state or federal law or rule relating to the practice of nursing in any state, territory or country?
   ☐ Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ No.
2. Have you ever violated a state or federal law or rule relating to narcotics or controlled substances or other similar regulations?
   ☐ Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ No.
3. Have you ever been convicted, entered a plea of guilty, *nolo contendere*, or no contest, for any felony, gross misdemeanor or misdemeanor offense? *NOTE: The fact that a conviction has been pardoned, expunged, dismissed, stayed, or deferred, or that your civil rights have been restored, does not mean that you answer "NO"; you should answer "YES."*
   ☐ Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ No.
4. In the last five years, have you ever misused or abused alcohol, other drugs or chemicals or been considered chemically dependent?
   ☐ Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ No.
5. Have you been fired from a nursing-related job in the last five years due to conduct that may be grounds for disciplinary action under the Nurse Practice Act?
   ☐ Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ No.
6. Are you under investigation or are you the subject of any pending or past disciplinary action or have you ever been refused a nursing license or any other occupational license in any state, territory or country?
   ☐ Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ No.
7. Do you have any physical or mental disability or illness that may impair your ability to practice nursing with reasonable skill and safety?
   NOTE: *If you are currently participating in the Health Professionals Services Program (HPSP) for this illness, you may answer "NO" to this question.*
   ☐ Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a statement explaining management and treatment is attached.
   ☐ Yes, this has previously been reported by me to the Minnesota Board of Nursing and a statement explaining management and treatment is attached.
   ☐ No.
8. Have you ever received notification from the Minnesota Department of Human Services or the United States Department of Health and Human Services, Office of the Inspector General that you have been disqualified from providing direct care or excluded from participation in Medicare or Medicaid?
   ☐ Yes, this has NOT previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ Yes, this has previously been reported by me to the Minnesota Board of Nursing and a written explanation is attached.
   ☐ No.

I affirm that the statements and documents provided by me during the application process are true and correct.

_____ _____

Legal Signature Date (mm/dd/yyyy)

Minnesota BOARD OF Nursing

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CONFIRMATION OF PROGRAM COMPLETION - ADVANCED PRACTICE REGISTERED NURSE

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine your eligibility and/or qualifications for the license for which you are applying; enable us to contact you when necessary; identify you and comply with certain federal and state reporting requirements.

Until you are licensed, all data submitted on this form, except your name and address, are considered private data and will not be released to anyone other than Board of Nursing staff and its agents. When you become licensed, all data submitted on the form become public record. Some or all of the data may be given to the Commissioner of Revenue, the Legislative Auditor, in response to a court order, or others in accordance with statutes, rules and professional standards.

You are legally required to submit true and complete information. Furnishing the requested information means the information may be provided to parties listed above. Refusal to supply information may result in denial of a license. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

•Type or print clearly•Use black ink •Provide all information •Incomplete applications will be returned •Do not use initials or abbreviations

APPLICANT INFORMATION

Complete the applicant information. If you do not have a graduate education as an APRN in one of the four roles and one of the six population foci, check the appropriate box and verify that you were recognized by the Minnesota Board of Nursing to practice as an APRN on July 1, 2014. This means that the Board had a current copy of your certification as an APRN. If you do not have a graduate level education and you were not recognized by the Board of Nursing to practice as an APRN on July 1, 2014, you are not eligible for licensure as an APRN in Minnesota. Sign and date the document. The *Affidavit Section* is to be completed by the school official of the APRN program you attended. Mail the document to the appropriate APRN program.

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
MAIDEN NAME	OTHER LAST NAME(S)	PHONE NUMBER ☐ Home ☐ Business ( )
MINNESOTA LICENSE NUMBER ☐ RN _____		BIRTH DATE (mm/dd/yyyy)
APRN PROGRAM NAME (no initials)		
CITY AND STATE OF APRN PROGRAM		COMPLETION DATE (mm/dd/yyyy)

☐ I authorize _____(name of APRN program) to release my educational dates to the Minnesota Board of Nursing.

☐ I do not meet the requirements for completion of graduate level education as an APRN in one of the four APRN roles and population focus.
☐ I was recognized by the Board to practice as an APRN prior to and on July 1, 2014.

_____ _____
Legal Signature Date (mm/dd/yyyy)

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Applicant: Complete the *Applicant Information* section above and forward to your school of nursing for completion. If the school official is not able to verify completion of all requirements, contact the Board of Nursing for further instructions.

School Official: Complete *Affidavit* section below.

AFFIDAVIT SECTION
⬇ This Section for School Use Only - Applicant: Do Not Write Below This Line ⬇

SCHOOL OFFICIAL: Complete Affidavit Section after the above named applicant has fulfilled all the requirements of the nursing program and is eligible for graduation.

PROGRAM INFORMATION

Was the APRN program at a graduate level? YES ☐ NO ☐

ROLE PREPARATION:

☐ Nurse Practitioner ☐ Registered Nurse Anesthetist ☐ Clinical Nurse Specialist ☐ Nurse Midwife

POPULATION FOCUS:

☐ Adult-Gerontology ☐ Family and Individual ☐ Neonatal ☐ Pediatric ☐ Women's and Gender Health

☐ Psychiatric and Mental Health

☐ Acute (if applicable) ☐ Primary (if applicable)

Is the program accredited by a national nursing accrediting agency? YES ☐ NO ☐

Is approval of the nursing program required by the Board of Nursing? YES ☐ NO ☐

Name of the Board of Nursing granting program approval _____

NAME OF ACCREDITATION BODY	DATES OF CURRENT ACCREDITATION (mm/dd/yyyy-mm/dd/yyyy)
DEGREE TYPE ☐ Doctorate of Nursing Practice ☐ Masters ☐ Other (explain) _____	COMPLETION DATE (mm/dd/yyyy)

The undersigned does hereby affirm that the information provided is true and correct.

_____
Signature of School Official

_____ Affix School Seal or Stamp
Name and Title (print)

Return completed form to Minnesota Board of Nursing

Minnesota BOARD OF Nursing

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POST-GRADUATE PRACTICE VERIFICATION

The information and evidence you are asked to provide on this form is authorized by Minnesota Statutes. The data you supply will used to verify completion of 2,080 hours of post-graduate practice for Nurse Practitioners and Clinical Nurse Specialists.

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine your eligibility and/or qualifications for the license for which you are applying; enable us to contact you when necessary; identify you and comply with certain federal and state reporting requirements. Minnesota Statute 270C.72 requires applicants to provide their Social Security number and Minnesota business identification number on all license applications.

Until you are issued a license, all data submitted on the application, except your name and address are considered private data and will not be released to anyone other than Board of Nursing staff and its agents. When you become licensed, all data submitted on the application, except social security number, become public record. Some or all of the data may be given to the Commissioner of Revenue, the Legislative Auditor, in response to a court order, or others in accordance with statutes, rules and professional standards.

You are legally required to submit true and complete information. Furnishing the requested information means the information may be provided to parties listed above. Refusal to supply information may result in denial of a license. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

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APPLICANT INFORMATION

This section must be completed by all CNS and CNP applicants.

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE / COUNTRY
EMAIL ADDRESS		
MINNESOTA LICENSE NUMBER ☐ RN _____	BIRTH DATE (mm/dd/yyyy)	GENDER ☐ Male ☐ Female
UNITED STATES SOCIAL SECURITY NUMBER Required by Minn. Stat. Sec. 270C.72 ___ - ___ - ____	☐ I do not have a US Social Security number at this time but will notify the Board if/when I obtain a US Social Security number	MINNESOTA BUSINESS IDENTIFICATION NUMBER Required by Minn. Stat. Sec. 270C.72

Complete the Affidavit of Post-Graduate Practice Completion section or the Verification of Completion of Post-Graduate Practice section.

AFFIDAVIT OF POST-GRADUATE PRACTICE COMPLETION

This section must be completed by an APRN who was on the Minnesota APRN Registry as of July 1, 2014.

I affirm that I have completed 2,080 hours of post-graduate practice and was listed on the Minnesota APRN Registry as of July 1, 2014.

The undersigned does hereby affirm that the statements contained in this application are true and correct.

_____ _____
Print Name Date (mm/dd/yyy)

_____
Legal Signature

-over-

INITIATION OF PRACTICE

This section must be completed by an individual who is initially entering into practice as a Nurse Practitioner or Clinical Nurse Specialist. Provide information about the hospital or integrated clinical setting in which you are initiating practice below.

NAME OF HOSPITAL OR INTEGRATED CLINICAL SETTING	PHONE
ADDRESS	EMAIL

VERIFICATION OF COMPLETION OF POST-GRADUATE PRACTICE

This section must be completed by a Nurse Practitioner or Clinical Nurse Specialist who has completed 2,080 hours within the context of collaborative agreement within a hospital or integrated clinical setting where advanced practice registered nurses and physicians work together to provide patient care. Complete the actual completion date.

☐ I have completed 2,080 hours of APRN practice within the context of a collaborative agreement within a hospital or integrated clinical setting

COMPLETION DATE (mm/dd/yyyy)

_____ _____
Print Name Date (mm/dd/yyy)

_____
Legal Signature

_____ _____
Print Name of APRN or MD for Collaborative Agreement Date (mm/dd/yyyy)

_____ _____
Signature of APRN or MD for Collaborative Agreement Date (mm/dd/yyyy)

☐ Physician License Number _____

☐ APRN License Number _____

Return completed form to Minnesota Board of Nursing

Advanced Practice Registered Nurse Workforce Questionnaire 2014

You must provide this information as a matter of state law (Minn. Stat. 1440.51-011.052 and Minn. Rules 4695.0100-4695.0300). Your responses support statewide health workforce planning efforts in Minnesota. The information collected is classified as public. Per Minnesota Statutes, section 144.1485, you may request your practice addresses be classified as private if this classification is required for your safety. If you need assistance filling out this form, please call (651) 201-3838 or Toll Free (800) 366-5424.

Registered Nurse (RN) license number: _____

First Name _____ Middle Initial _____ Last Name _____

Section A: Training and Professional Information

1. What type of nursing degree or credential prepared you to practice as an APRN, regardless of where the license was obtained? (*Select only **ONE***)

- ☐ Diploma - Nursing
- ☐ Associate Degree - Nursing
- ☐ Bachelor's Degree - Nursing
- ☐ Post-baccalaureate certificate - Nursing
- ☐ Master's Degree - Nursing
- ☐ Doctorate

2. Did you obtain the degree or credential listed above in Minnesota?

- ☐ Yes
- ☐ No

3. What other degrees have you earned, if any? (*Select **all that apply***)

- ☐ Associate Degree, Nursing
- ☐ Associate Degree, Non-Nursing
- ☐ Bachelor's Degree, Nursing
- ☐ Bachelor's Degree, Non-Nursing
- ☐ Master's Degree, Nursing
- ☐ Master's Degree, Non-Nursing
- ☐ Doctorate in Nursing (PhD)
- ☐ Doctorate in Nursing Practice (DNP)
- ☐ Doctorate in Nursing (Other)
- ☐ Doctorate, Non-Nursing
- ☐ Post-Master's Certificate
- ☐ None

4. If you are currently practicing as an APRN, how many more years do you plan to practice in Minnesota?

- ☐ 5 years or less →
- ☐ 6-10 years
- ☐ More than 10 years
- ☐ Not practicing as an APRN in MN

If you answered #4 as "5 years or less," what is the main reason you plan to practice less than 6 years in MN?

- ☐ Retirement
- ☐ Work in another state
- ☐ Change professions
- ☐ Other (specify) _____

5. In the past 12 months, did you volunteer your time to provide nursing services?

- ☐ Yes; estimated hours in past 12 months _____
- ☐ No

6. Which of the following choices best describes your current employment status? (*Select only **ONE***)

- ☐ Employed in a paid position as an APRN
- ☐ Employed in another field, but seeking work as an APRN
- ☐ Employed in another field and not seeking work as an APRN
- ☐ Unemployed, but seeking work as an APRN
- ☐ Unemployed and not seeking work as an APRN
- ☐ Not currently working due to family or medical reasons
- ☐ Retired
- ☐ Student (*specify major, field or degree program)* _____

Section B: Employment Information

7. How many weeks did you work as an APRN in the past year? _____weeks

8. How many hours do you work as an APRN in a typical week? _____ (*On average*)

9. How many patients do you see in a typical week? _____ *(if none, write 0).*

Site One

*Please provide the following information about the site **where you work the most hours weekly** in a job that requires an APRN license. **If you are not working in a position that requires an APRN license, please skip to questions 19 & 20.***

10. Name of work site (clinic, hospital, university, etc.) _____

Street Address _____ **City** _____ **State** _____ **Zip code**_____

Site One *continued*

11. Number of years you have worked at this location _____

12. Number of hours you work in a TYPICAL WEEK at this location _____ *(On average)*

13. How many hours per week do you provide care directly to patients at this location? _____ hours per week

14. What type of practice setting best describes the site where you work the most APRN hours weekly?
*(Please select only **ONE BOX**)*

- ☐ Academic (teaching or research)
- ☐ Ambulatory care/Clinic
- ☐ Ambulatory surgical center
- ☐ Community/Public health
- ☐ Convenience/Retail/Walk-in clinic
- ☐ Correctional facility
- ☐ Drug/Medical device industry
- ☐ Federally Qualified Health Center
- ☐ Home health agency
- ☐ Hospice
- ☐ Hospital
- ☐ Insurance company
- ☐ Nursing Home/ Long-term care/ Extended care/Assisted living facility
- ☐ Policy/Planning/Regulatory
- ☐ Private industry/organization
- ☐ Rehabilitation facility
- ☐ School (K-12)/College/University health clinic
- ☐ Solo practice
- ☐ Urgent care clinic
- ☐ Other_____

Site Two

*Please complete the following information if you are working at an additional site requiring a current APRN license. This is the site **where you work the second highest hours weekly**.*

15. Name of work site (clinic, hospital, university, etc.) _____

City _____ **State** _____ **Zip code**_____

16. Indicate all specialties in which you practice (regardless of work site/practice setting). *(select **ALL** that apply)*

- ☐ Acute care/Critical care
- ☐ Adult Health/Family Health
- ☐ Anesthesia/Anesthesiology
- ☐ Community Health
- ☐ Emergency Care/Trauma
- ☐ Geriatric/Gerontology
- ☐ Home Health
- ☐ Hospice/Palliative Care
- ☐ Intensive Care
- ☐ Maternal – Child Health
- ☐ Medical/Surgical
- ☐ Neonatal/Perinatal
- ☐ Obstetrics/Gynecology (Women's Health)
- ☐ Occupational Health
- ☐ Oncology
- ☐ Operating Room/Recovery
- ☐ Pediatrics
- ☐ Psychiatric/Mental/Behavioral Health/ Substance Abuse
- ☐ Public Health
- ☐ School Health
- ☐ Other *(Please specify)*_____

17. Time spent in the following activities at your work site(s) (*On average*)

Activity	Time in hours in a standard week
Provide direct patient care	_____ hrs.
Supervise patient care	_____ hrs.
Administration of Practice	_____ hrs.
Case Management	_____ hrs.
Care Coordination with a Team	_____ hrs.
Insurance/Utilization	_____ hrs.
Telephone triage	_____ hrs.
Teaching/Research	_____ hrs.
School health	_____ hrs.
Public Health	_____ hrs.
Other_____	_____ hrs.

18. In addition to English, in which languages do you communicate for clinical purposes? *(Select **ALL that apply** or **"None"**)*

- ☐ None (English Only)
- ☐ Amharic
- ☐ Arabic
- ☐ Hmong
- ☐ Khmer
- ☐ Lao
- ☐ Oromo
- ☐ Russian
- ☐ Serbo-Croatian
- ☐ Sign Language
- ☐ Somali
- ☐ Spanish
- ☐ Swahili
- ☐ Vietnamese
- ☐ Other *(specify)* _____

Section C: Race and Ethnicity Information

19. Are you of Hispanic, Latino or Spanish origin? ☐ Yes ☐ No

20. What is your race? (Check ALL that apply)

- ☐ White
- ☐ Black/African American or African
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Other *(specify)* _____

Prepared by the Minnesota Department of Health
Office of Rural Health and Primary Care
(651) 201-3838 or Toll Free (800) 366-5424
www.health.state.mn.us/divs/orhpc/workforce

Please return this form with your license application
Advanced Practice Registered Nurse